

# South Carolina Department of Disabilities and Special Needs

## Report on Administrative Review of Alleged Abuse, Neglect, or Exploitation -- ICF/MR Facilities

(Provide brief summarized information in this report—explicit details should be provided according to the Outline of Report)

The Administrative Review is conducted immediately when an ICF/MR (Community or Regional Center) resident is allegedly abused, neglected or exploited, including when a resident is at a day program.

Reviewer:	Name:	Position:	Date/Time Appointed:
Provider:			
Victim 1:	Birthdate:	Victim 3:	Birthdate:
Victim 2:	Birthdate:	Victim 4:	Birthdate:
Alleged Perpetrator(s)	Name & Title (indicate which victim #)		
Witnesses:			
Residence of Consumer(s):	DDSN Contracted Provider (ICF/MR): <input type="checkbox"/>		DDSN Regional Center (ICF/MR): <input type="checkbox"/>
	Descriptive Location of Residence: (i.e., Doe ICF)		
<b>INCIDENT:</b>			
Date of Incident:		Time of Incident:	<input type="checkbox"/> AM <input type="checkbox"/> PM
<input type="checkbox"/> Date of Incident Unknown	If Date of Incident is unknown, indicate Date Incident Reported (shown on Initial Report):		
Type Location of Incident:	DDSN Contracted Provider (ICF/MR): <input type="checkbox"/>		DDSN Regional Center (ICF/MR): <input type="checkbox"/>
	Day Service: <input type="checkbox"/>		Other: <input type="checkbox"/> Specify:
Descriptive Location of Incident: (i.e., Doe ICF)			
Type of Suspected Abuse:	<input type="checkbox"/> Exploitation <input type="checkbox"/> Neglect <input type="checkbox"/> Physical <input type="checkbox"/> Psychological <input type="checkbox"/> Sexual		
Description of Incident (brief summary):			
Nature and extent of injury/harm & medical treatment received:			
<b>ISSUES/RISK SITUATIONS IDENTIFIED:</b>			
<input type="checkbox"/> Personnel Actions	Comment:		
<input type="checkbox"/> Staff Training	Comment:		
<input type="checkbox"/> Environmental Modifications	Comment:		
<input type="checkbox"/> Policy/Procedure Violations	Comment:		
<input type="checkbox"/> Local Services Contract	Comment:		
<input type="checkbox"/> Awareness Training for People Served	Comment:		
Recommendations Pertaining to These Issues/Situations:			
<b>REVIEW OUTCOME:</b>			
<input type="checkbox"/> Rules, Regulation or Policy Violation(s) (Specify which rule, regulation or policy was violated):			
<input type="checkbox"/> Management Action Taken (Specify what action was taken):		<input type="checkbox"/> Other (Specify):	
Executive Director/ Facility Administrator/ CEO Comments:			
<b>ACTION TAKEN/TO BE TAKEN:</b>			
Personnel Action Taken:	<input type="checkbox"/> Administrative Leave W/Out Pay <input type="checkbox"/> None <input type="checkbox"/> Transferred	<input type="checkbox"/> In-Service Training <input type="checkbox"/> Reinstatement <input type="checkbox"/> Unknown	<input type="checkbox"/> Legal Charges <input type="checkbox"/> Resignation/No Longer Works for Agency <input type="checkbox"/> Verbal Reprimand <input type="checkbox"/> NA/No Staff Involved <input type="checkbox"/> Written Reprimand
Comments:			
Abuse Prevention/Corrective Action to Avoid Reoccurrence: (Include each action, completion date, staff responsible for implementation of each action & staff title)			
Other Action Taken:			

**OUTSIDE INVESTIGATIVE AGENCIES:**Has an investigation by an outside agency been completed? ☐ Yes ☐ NoOr, is case still under investigation by an outside agency? ☐ Yes ☐ No

Agency	Date of Referral	Contact Person	Intake # or Case ID #	Result of Agency's Investigation If Known at Time of Completion of Administrative Review
<input type="checkbox"/> DSS				
<input type="checkbox"/> Local Law Enforcement				
<input type="checkbox"/> Ombudsman				
<input type="checkbox"/> SLED				
<input type="checkbox"/> Attorney General				
<input type="checkbox"/> Other (Specify):				

**FINDINGS BASED ON ADMINISTRATIVE REVIEW:***(Please provide only brief summarized information pertaining to the conclusion of the review)*

**Disposition of Abuse Allegation:** ☐ Substantiated/Founded (Perpetrator Known) ☐ Substantiated/Founded (Perpetrator Unknown)  
**(at time of review)** ☐ Unsubstantiated/Unfounded ☐ Other Agency Investigating

**OUTLINE OF REPORT** *(Attach detailed information according to this outline which pertains to the alleged abuse):***A. Chronology of Events**

This section shall include in paragraph form, the re-creation of the events prior to, during, and following the incident of alleged abuse. It shall contain, to the extent possible, the names of the individuals, their action, and the time frame during which the alleged abuse occurred.

**B. Discussion**

This section will list all facts of the case.

**C. Conclusion****D. Supporting Documents to be Included**

1. Signed and dated statements from each person involved
2. Unusual Occurrence Form
3. Photographs
4. OD Report
5. Injury Report
6. Other documents, if needed during the Administrative Review, such as:
  - a. Body check report
  - b. Doctor/Nurse reports
  - c. Work schedule
  - d. Security report

**SIGNATURE**

Executive Director/ CEO/ Facility Administrator (or Designee)	Date	Name of Person Completing Form
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Send completed forms within five (5) working days (excluding state and federal holidays) of discovery of suspected abuse, neglect or exploitation to:  
 Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX # 803.898.7450